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Citation

Glover, Denise M. 2016. "Viral Signs: Confronting Cultural Relativism with Children's Health in the Field." In *Doing Fieldwork in China...with Kids! The Dynamics of Accompanied Fieldwork in the People's Republic*, Candice Cornet and Tami Blumenfield (eds). NIAS Press. Pp 87-99.

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Viral Signs

Confronting Cultural Relativism with Children's Health in the Field

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Some days it is hard to be a parent, while other days it is marvelous and without angst. Sometimes fieldwork can be exhilarating, at other times exhausting. When parenting and fieldwork are combined, these impressions can be heightened to an extent that we become more aware of our positionality as both researcher and parent and the challenges that these two occupations can bring, particularly when merged. My son was a year-and-a-half old when I first went to Rgyalthang (now Shangrila), in northwestern Yunnan Province, in 1999. He became ill. Not seriously, but enough that it made me consider whether I was prepared to face the possibility of dealing with a more serious illness in the future. Ironically, I was there to study medicinal plant knowledge. But I soon lost my ability to be a cultural relativist when faced with a potential health crisis in my own child. This formative experience made me examine closely my inability to detach from my own cultural convictions while at the same time studying local medicine. Here I explore what I see as the most central issues that emerge in this tension between being a cultural being oneself and being the researcher of culture on the other. In particular, I explore my own reading of signs, embedded as it is in a cultural worldview, and how my attachment to this reading is especially tenacious in my role as a parent, at once a biological, social, cultural, moral, and emotional role. This insight is important for fieldwork reflexivity, and is essential in comprehending what it is we do as anthropologists.

When my husband and I brought our young son to the heights of the Rgyalthang plain, we were initially concerned with

keeping him safe from the open sewer pits that were scattered in the area where we were living. He was of an age where an open stretch of space ahead must have looked like an airstrip of possibilities from which to launch his curious self. We were constantly running after him, much to his delight (shrieks of excitement seemed to propel him forward) until we scooped him up or diverted him to safety. But soon after we arrived (within the first month), he came down with a fever and broke out in blisters on his mouth and hands. I sought treatment for my son with practitioners of both Chinese and Tibetan medicine for this illness. First, my friend, a doctor of Chinese medicine, offered his help with diagnosis and treatment; I accepted and thought that the bitter concoction he prescribed might help and certainly would not hurt. But, as anyone who has ever taken Chinese medicine will understand, it was challenging to get my son to drink the medicine; every time he tried he gagged and spat it out. Soon he would not open his mouth. I abandoned the idea of forcing it down his throat; it hardly seemed like a wise choice. Later, when a large blister formed on his thumb, we went to the Tibetan hospital (where I ended up spending the majority of my time during fieldwork in 2001 and 2002) but I could not help my startled reaction as doctors reached for a needle sitting in an old coke can to open up the blister. I asked if the needle had been sterilized and was told 'no problem, no problem (*meiyou wenti*).'¹ At that moment, I was torn between my conviction that the needle was likely not sterilized (at least not recently) and my role as an open-minded anthropologist accepting of local healing customs. I opted for the 'professional' approach: I let them open up the blister with this needle. However, I worried about the wisdom of my choice.¹

I accepted these various treatments, but in my mind my son's illness was likely caused by a virus; my cultural conviction of germ theory won out over being able to see his illness as an imbalance of humors, an excess of heat in the body, a stagnation of *qi* (life force) – all possible explanations from the theoretical perspectives of Tibetan and Chinese medicines – or as explainable with reference to any other set of ideas.² Those explanations could potentially be accurate, but in general I ruled them out as not believable; in the universe of all possible explanations, I was drawn to the one that I was most comfortable and familiar with – and the one that I was most convinced by. Perhaps I had still a lot to learn about being a 'real' anthropologist. *What would Malinowski have thought and done? Surely he would have been more accepting of local practices, wouldn't he? But maybe he would have written otherwise in his diary. Ah, but he carried a medical kit with him, did he not?* I mused. Significantly, Malinowski never had one of his own children with him in the field.³

I struggled during those first few months with many issues that new fieldworkers undoubtedly have; the concern with how to balance research/work with family was of course one of them. After I returned to the States that summer, I explained my dilemma to my advisors. I felt that it was difficult for most of them to understand, perhaps because the majority were men (and therefore fathers, not mothers⁴) or perhaps because they had had their children in the field so long ago that they were too far removed from their own similar experiences (if indeed they had had any); two had done most of their significant fieldwork before having children. I was considering delaying fieldwork until my son was a year older. Several advisors worried that this was a bad idea, that I would probably not make it back to China; most thought it was probably an okay idea – neither great nor terrible.

Then one of my advisors told me that I should not take illness in the field lightly. He disclosed to me that he had lost a child to illness while doing fieldwork approximately thirty years previously. Not many people knew (or know, even now) this about him. I was in tears while he told me that his daughter had contracted a respiratory infection from which she never recovered. She died in the field. He said that he had not wanted to say anything about this before I left for my preliminary fieldwork, but that it seemed appropriate to tell me now that I was back and had worries about my son's health. He told me to trust my feelings of unease, not to doubt them. I walked away from that conversation stunned; I could not stop thinking about it. Indeed, I still think about it nearly fifteen years later. As Christine Hugh-Jones (1987) has written about her own worries before heading off for extended fieldwork in the Amazon: 'Statistics [e.g., more likelihood of dying in a car accident than by a poisonous snake bite in the field] may help us decide things in a cool and rational fashion, but it is impossible to arrange emotions in a statistical model. Once disasters have happened, they have happened 100 per cent' (1987: 42).

Based partly on the conversation I had with my advisor – here was a *real person* that I knew, not just a number in a small percentage of people who have lost children in the field – and my own experience of anxiety, I decided to wait until my son was a bit older to return for more extended fieldwork. In the end he never got very sick again, but I made sure that we departed for fieldwork having had all recommended immunizations for extended stay in the PRC, and with a supply of antibiotics, antibacterial ointment, packets of powdered electrolyte mix, Benadryl, bandages and our own syringes.

Granted, this was a formative experience in the field as a new mother – and a neophyte fieldworker. However, thirteen years and several more stints

of fieldwork (with children) later, many of my convictions remain. In May 2012, my son and my daughter (ages 14 and 7 at the time) and I returned for a brief stay for research purposes. Since my daughter had developed a cold two days before departure, I made sure to bring antibiotics with us (which we did in fact use for the apparent ear infection that ensued). When the antibiotics did not seem to be working and her fever persisted, I sought out a doctor of Western medicine to examine and treat her. He suggested continuing with the antibiotics and giving it some more time, and she eventually did get better. Why did I not ask my Tibetan doctor friends to treat her? This may have to do with my more extensive experience (compared to thirteen years previously) as a mother. Like many parents, I have become at least an advanced novice in lay diagnosis. Repeated experiences with what are labeled 'viral' and 'bacterial infections' in biomedicine provided convincing evidence that what my daughter was experiencing was one which could be described in those terms. I read the 'signs' in just that way. As Paul Stoller has argued, reading signs is a 'subjective action the depth of which is shaped by our set of experiences' (1982: 760). Having two children who had both experienced ear infections previously, I was quite confident in my own reading of the signs; since I knew that antibiotics work for the disorder of an ear infection, I went with what I knew to be effective.

David Sutton (1998) discusses the challenges of cultural relativism in relation to his son's health during his fieldwork in Greece. Generally speaking, cultural relativism refers to the ability to *understand* cultural practices, behaviors, and beliefs with reference to the socio-cultural context in which they occur; this is the cornerstone of cultural anthropology, this is what all anthropologists are aiming for at a bare minimum. Cultural relativism has also been infused with a morally-charged sensibility of *not judging* or measuring cultural practices according to the standards set by another culture (or even 'universal' standards); this type of cultural relativism is much more controversial.⁵ While these two meanings of cultural relativism can stand alone as comprehensively distinct, the real difficulty comes with implementing the more extended meaning (lack of judgment) when it involves *action* on the part of the anthropologist, since by and large action in the world requires the use of judgment. Sutton argues that being a cultural relativist is especially difficult when it comes to issues of health (and illness):

Such [difficulties with tolerance of] child care practices were complicated by the fact that for myself and for the Kalymnians these practices often

entered the realm of medical authority, that is, they seemed to escape the category of 'culture.' While I would not dream of passing judgment on the Kalymnian use of protective talismans for the evil eye, it was quite another matter when the practice at hand seemed to enter the realm of health rather than belief. (Sutton 1998: 132–133)

Sutton's simple dichotomy between a realm of 'health' and one of 'belief' can be challenged, but he touches on an important point about the way that health practices can be viewed in many ways as distinct from other cultural practices; the question is why? I will return to this point below. What I would argue first is that what is most crucial here – which Sutton himself does not seem to fully recognize – is that it is the health of his *child* that is so central to this challenge. Why are our own cultural convictions related to health and illness most heightened in our role as parents? For my own health, I have readily accepted – and found successful – treatment from doctors of the Tibetan and Chinese medical systems. While living in Hawai'i as a beginning graduate student, I developed pneumonia; after three rounds of antibiotics and no success in clearing my lungs, I sought out a doctor of Chinese medicine. He prescribed snake bile, which I took for ten days and which cured me.⁶ Once, I sprained my ankle quite severely when hiking out of a small village near Khawakarpo Mountain (near Rgyalhang); when I could barely walk the next day, I sought out the treatment of a Tibetan doctor at the nearby clinic. The doctor massaged my ankle so intensely that I cried. 'I know,' she said, 'it hurts. But it's supposed to hurt and what I'm doing will make it much better.' She then applied a mixture of herbs onto my ankle and wrapped it with gauze and plastic. The next day my ankle felt nearly normal again; I was amazed. Another time, I was under the care of Pema Tenzin, one of the doctors with whom I studied closely in Rgyalhang. Since the birth of my son, I had been experiencing occasional 'unexplainable' hives; I went through a variety of tests in the States to determine what was causing these hives, but my doctor could not find a cause – and there was no treatment suggested. When I was in Rgyalhang, the hives returned, so I asked Doctor Pema Tenzin if he would help treat me. His treatment, which included a slight change in diet and taking three different pills three times a day, worked. I was impressed and duly convinced by the efficacy that I experienced. More than a decade after the main part of my fieldwork, I am a fairly regular consumer of various therapeutics of Chinese medicine (acupuncture, cupping, ingestion of herbal formulas).⁷

So, why the difference when it comes to children's health? From my own personal experience, I entertain several possible explanations (which may or

may not be applicable in other settings). One possible explanation – which I believe is the most likely – is that it could have to do with the nature of the disorders. Or, more importantly, the way in which I read the signs of the disorders. The sign of *fever* was present in my children's illnesses, but not in my own (with the exception of pneumonia – but recall that I did not initially go to a Chinese medical doctor). From the perspective of germ-theory, fever is a sign of viral or bacterial infection. Sprained ankles are not caused by 'germs'; and hives, rarely so. Perhaps the 'viral sign' of fever is a most convincing cultural orientation for me, but other signs of health disorders are not.

Another possible explanation is that the fundamental difference in my responses to health crises in my children, compared to those in myself, has more to do with power and agency, particularly as these relate to healing. First, a significant aspect of healing has to do with the power of 'belief.' Since my children had not been immersed in a world in which *qi* and humors are part of common sense and therefore part of their possible belief system, but had been more immersed in a world saturated with belief in antibiotics, I had little conviction that the treatments would be successful (let alone how this might interact with their already heightened senses of vulnerability, being so far from home). For myself, however, I am much more confident in the efficacy of these medical systems. This could relate, in part, to my own experience of healing success with pneumonia, sprained ankles and hives; or to my academic study of Tibetan and Chinese medicines, and knowledge of the longevity of these medical systems. In either case, seeing the efficacy reported and the powerful belief in such efficacy have an effect on my own convictions – to an extent. (*Ah, but what about those 'dirty' looking needles – how much confidence did I really have in those?* I will return to this point below.) Second, I was making decisions about my own body when seeking treatment for myself – not so for my children. Are we more willing to accept risk and behave in potentially 'foolish' or at least uncertain ways when it comes to our own bodies, compared to those of our children?⁸

The last possibility, of course, has to do with a potentially loaded interpretation. But it may, in fact, be the most culturally embedded one. Perhaps there is an element of truth to germ theory. Perhaps any culturally relativist stance which would lead one to reject the 'objective reality' of viruses and bacteria is simply wrong. Perhaps this is what Sutton meant when he said that there are two 'realms': one of 'health,' or, one could argue, biology; and the other of 'culture.'⁹ This is most likely the stance that most – although not all – doctors trained in biomedicine would take. And, this may be most North Americans' perspective as well. Undoubtedly, this view is at the heart of my conviction

about germ theory; I am convinced that viruses and bacteria are real. We have *evidence* that they are real – they can in fact be seen directly, with the help of magnification. This is simply a ‘fact’ in most Euro-American cultural contexts, not a ‘belief,’ we are sure. This orients me as a cultural being. Viruses may be ‘real’ or not, in some ultimate, ontological sense, but what really matters is that I have been enculturated to see them as real; this conviction influences my orientation to the world. This is relevant because, in making decisions about my health and that of my children’s, I have not only to *think*; I have to *act*.

Again, it is possible that all of these interpretations could be simultaneously accurate. The main point that I wish to emphasize here is that, in relation to any of these options, the choices that I made in terms of my children’s health were based on my cultural positionality as a parent. I expressed my ‘prejudice’ for a biomedical explanation as a cultural being – a mother. And my previous experiences as a mother led me to make particular choices. What is fascinating about kinship – and the idea that one has duties as a member of some kin group – is that it is so widespread and powerful. Michael Wesch (2007) discusses this in the context of a witch hunt in which he became embroiled during his fieldwork in Papua New Guinea. Before becoming enmeshed in life in Papua New Guinea, Wesch explains that he had an ‘open mind’ about the idea of witchcraft (and belief in witches), understanding the important ‘functions’ that belief in witchcraft provides for communities. Even while in the field, he remained a cultural relativist (in terms of witchcraft) for quite some time, until his fictive father was accused of witchcraft. It was at that moment that Wesch realized not only that he does not believe in witches, but that he had to act as a ‘good son’ and protect his father. In coming to this realization, he notes that he was now able to act as a cultural being. He states:

I discovered a freedom to express myself beyond my constrained scientific observer status precisely because I was related. My vigilance and anger could be read relationally. If I protested the idea of witchcraft beliefs or challenged the legitimacy of a court ruling, it was because I was concerned for my auntie or my father; I was not acting outside the boundaries of what was locally acceptable. On the contrary, as I stepped out from behind my recording microscope [his camera] and made such protests, I may have become acceptable for the first time since the witch hunt began. After all, what kind of son would I be if I did not protest? (Wesch 2007: 14).

While many of us worry that our cultural biases might label us as non-objective, non-scientific, or non-relativist, we can argue here that *while this*

may be true (yes, objectivity falls away when one expresses one's biases), it may be equally important to express our 'humanity' and our concern with familial responsibilities – both to 'insiders' and 'outsiders' of a cultural community – while conducting fieldwork. Otherwise, what kind of people are we? Our cultural biases make us fully human. And while one of the key tenets of cultural anthropology is that practices and beliefs need to be understood within a cultural context and that we should therefore usually suspend judgment on them, sometimes an exercise of judgment on our part is necessary; to deny that capacity and right to judgement is to deny our humanity. The trick is being able to discern which types of judgment we can sustain while still being legitimately engaged in the practice of understanding cultural 'others.'

What of China in all of this? In China, the supposed 'divisions' that exist in medical practice and beliefs between germ-theory and other systems (such as Tibetan and Chinese medicines) are not terribly fixed, due to the inclusion of biomedical understandings in the professional and public discourses of health and illness in the PRC. Germ theory is no longer a terribly 'foreign' idea. In fact, both the doctors of Tibetan medicine that I worked with in Rgyalthang and others in China and the States with whom I have discussed this have explained to me that 'germs' (*srin bu* in Tibetan) are recognized by Tibetan medical theory as causative agents in illness; they are just not usually targeted directly – unlike within the biomedical approach to the use of antibiotics. My own survey research in Rgyalthang (Glover 2005; 2007) indicates that medical pluralism is alive and well; people choose treatments from among Tibetan, Chinese, and biomedicine strategically, deciding largely, although not exclusively, based on perceived efficacy. Antibiotics are used, possibly overused, throughout most of the PRC now; I was able to purchase antibiotics over the counter at a pharmacy in Rgyalthang in 2009 (although I was told by an American biomedical doctor living in the area that such antibiotics are not very high quality). Craig Janes reported in 2002 that medical pluralism was quite widespread in many of the more populated Tibetan towns and cities (Janes 2002: 268); Mei Zhan (2009) argues for much the same 'transnational entanglement' (as she terms it) of biomedicine and Chinese medicine in the early 2000s in the PRC as well as in the States. Thus the cultural 'divides' that cultural relativism assumes are partly illusory.

Again, Michael Wesch addresses this issue with his experience in Papua New Guinea. Partly through his adoption into the local community as a son, and partly through his recognition of the level of cultural complexity and inter-mixing that exists in the world, he notes that invoking cultural relativism is often



Figure 4.1. The author's son, August Avantaggio, at age 3 (in 2001) in Rgyalthang. August prepared 'medicine' of found herbs and grasses that he picked himself for this injured sheep; the healing project was completely his own initiative. Although very young, August was able to comprehend the significance of his mother's fieldwork, the study of medicinal plant knowledge, at least at some level. Photograph: Denise M. Glover.



Figure 4.2. August Avantaggio in 2012 on the road from Nizu to Rgyalthang. By the time he had returned to northwest Yunnan for the fifth time, August had found some interests of his own (here, photography) to pursue in the field. Photograph: Denise M. Glover.



Figure 4.3. The author's daughter, Saveria Avantaggio, feeling better after her stint of illness in Rgyalthang, 2012. Photograph: Denise M. Glover



Figure 4.4. The author and her children on the day of their departure for the field in May 2012. This photograph was taken at their home by the author's husband / the children's father, Glen Avantaggio, who did not accompany them to the field on this trip.

not as simple as our introductory texts in cultural anthropology make it out to be. He quotes Barnes (1963:124) in saying: 'the division between those under the microscope and those looking scientifically down the eye-piece has broken down ... [T]he group or institution being studied is now seen to be embedded in a network of social relations of which the observer is an integral if reluctant part' (Wesch 2007: 10). Contemplation of cultural relativism as a 'creed' (Cohen 1989) and the socio-political situation of medical practice in China merge to show that simple divisions are not always tenable; as Paul Farmer's work examining the simultaneous use of both sorcery healing and biomedical medicines for tuberculosis in Haiti and Sienna Craig's (2012: 112–145) examination of both divinatory- and materialist-based curing in Tibetan medicine demonstrate, complexity is implicit in the work of healing.¹⁰ In fact, in many ways I was acting just like most other mothers in Rgyalthang themselves might have acted: making the wisest choice from among many health-care options for my children, based on my responsibilities as a mother. Rgyalthang mothers likely would consider various options as well, including consultation with lamas and/or divinatory practices that rely on the expertise of other types of healers. How I read the sign of fever may be different (for me, it is a 'viral sign'), but my decision-making process is not terribly dissimilar from theirs. In short, we are

all trying to make order out of the disorder that illness brings (Stoller 2004). In this context, the 'difference' between us fades away; we become more human, and thus more real, to each other.

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Endnotes

1 My husband and I were both present for this procedure and were in agreement about this choice. Although I use first-person throughout to describe my own thoughts and reactions, as this is written from my perspective, in general many of these decisions were made by the two of us as parents (unless otherwise noted). For more than half of my fieldwork I was alone with my son as a single parent of sorts, although I regularly spoke with my husband via phone. See both Cornet, Chap. 7 this volume and Blumenfield, Chap. 3 this volume, for discussions about single-parenting in the field.

2 Both Tibetan and Chinese medicines are effective and rational systems of healing, with extensive longevity. While there are some important connections between the two systems, there are some significant differences as well. Tibetan medicine is more closely aligned to its Ayurvedic sibling with an explanatory framework of three fundamental humors in the body, the imbalance of which can cause disorder. In Chinese medicine, the flow of 'life energy' (*qi*) in the body is fundamental to good health, and disruption or dysfunction in this flow can cause ill health. Both systems use a variety of therapeutics, including external ones (acupuncture, massage, cupping, baths) as well as internal ones (ingestion of medicines, variously made with plant, animal, and mineral ingredients). In both systems, diet and behavior are seen as having significant effects on health; perhaps because of this (and other reasons), there has been a significant increase in interest within the past several decades among populations in North America and Europe in these medical systems as many of the concerns of 'healthy lifestyles' seem to coordinate well with concerns about diet and behavior.

3 A recent film by Malinowski's great grandson, Zachary Stuart, confirms that Malinowski did not involve any of his family members directly in fieldwork. See *Savage Memory*, Sly Productions, 2011 (<http://www.savagememory.com/>).

4 While I am not claiming that there is necessarily a biological explanation for the different experiences of parenting between males and females, there is certainly a culturally gendered difference.

5 There has long been a healthy debate in anthropology about this issue, dating perhaps as far back as post-WWII with the realization that notions of cultural relativism could easily be misconstrued if used as an 'excuse' for Nazi atrocities. The significant distinction which came out of this debate that I am highlighting here has also been termed 'descriptive vs. normative relativism' (Spiro 1986) as well as 'cultural vs. moral relativism.' See also Cornet, Chap. 7 this volume, and Hansen, this volume, which both discuss issues of cultural relativism.

6 This experience was a formative one that started me on the path of interest in Asian medical systems and is a story that I tell often to my students; it highlights the degree to which subjective experiences can be some of the most meaningful for pointing us towards interesting and engaged anthropological inquiries.

7 Recently I asked my son if he would consider seeing a doctor of Chinese medicine to cure a persistent runny nose that he has had. Now age 17, he had some of his own ideas about health and illness and what to do to feel better when sick. At first he said 'no thanks' to my query, but then about a week later he seemed to change his mind and said he would be willing to consider it. In the end, he got over the cold before we could get an appointment scheduled. He has used an 'alternative' (more from the naturopathic tradition) mushroom-based anti-viral supplement that I also use, so he does appear to be open to non-biomedical treatments.

8 Clearly there are cultural models of parenting, embodiment, and body technologies (Palmer 2007) that could be explored here as well.

9 Such a simple dichotomy has been challenged by sociologists and anthropologists of science such as Bruno Latour (see Latour 1999, especially Chapter 5, titled 'The Historicity of Things: Where were the microbes before Pasteur?') but in fact I would argue that this dichotomy is the basis of the way in which we (North Americans) commonly conceptualize differences in healing practices.

10 One of my favorite quotes from the biography about Farmer, titled *Mountains Beyond Mountains*, is a response that Farmer received when querying a woman for believing that TB was caused both by germs and by sorcery: 'Honey, are you incapable of complexity?' (Kidder 2004: 35).

